Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Regulation of Health and Social Care Services

Annual overview report on the inspection and regulation of children's services – 2019

June 2020

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services —** Regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

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A message from the Chief Inspector of Social Services and Director of Regulation

Mary Dunnion, Chief Inspector of Social Services and Director of Regulation

This report reviews the work undertaken by the Health Information and Quality Authority (HIQA) and the Chief Inspector of Social Services in relation to their monitoring and regulation of children's services in Ireland during 2019. It gives an insight into the quality and safety of these services, and importantly, it reflects what children have told us about their experience of these services.

Because we believe no programme of regulation should operate in a vacuum, each year of regulatory activity is linked to, and builds on, our work of the previous year. So, for 2019, this involved:

- concluding our focus on aspects of services that had started the previous year (in 2018):
- developing a new programme of inspection that:
  - acknowledges those children's services that have the capacity to self-assess themselves against national standards
  - supports the development of a coherent plan to respond to issues and areas of learning identified in services on inspection
- and finally, responding to identified risk:
  - indicated in unsolicited information, which is information we receive from the public, such as information that may be of concern from people who use services
  - indicated in our monitoring and inspection findings.

To that end and in order to promote and support quality improvement, during 2019, the Children's Team implemented a focused programme of inspection to assess a number of key areas of foster care services. These included how services assessed the needs of children in foster care, the care planning and review process — including preparation and planning for leaving care, matching and safeguarding. This was a natural progression from our monitoring programme of 2017 and 2018 which

focused on the assessment, approval, review, supervision and support of foster carers.

While this overview report summarises key findings from 11 foster care inspections carried out in 2019, we also plan to publish a separate overview report in due course setting out the quality of care experienced by children and young people living in foster care placements in all 17 service areas within the Child and Family Agency (Tusla).

Following the 2018 HIQA investigation report into the management of allegations of child sexual abuse, we committed to developing a quality improvement inspection programme (what we term a 'thematic programme'), for Tulsa's child protection and welfare services. The approach of this programme was to be informed by the investigation's findings.

Thematic programmes aim to improve the quality of a specific area of a service. In this instance, this was the point of a person's initial contact with Tusla to report a child protection and welfare concern; the screening and enquiry process around such concerns; and the later safety planning and assessment of children as deemed appropriate.

While the HIQA investigation had the specific task of examining the management of child sexual abuse allegations, the thematic programme that we rolled out included Tulsa's management of all child protection and welfare referrals. In line with how HIQA conducts thematic inspections and based on our prior regulatory knowledge of services, we selected 12 out of 17 Tusla service areas in which to conduct these inspections in 2019 and 2020. Services were selected based on their assessed capacity, based on previous inspection findings, to improve and apply any learning arising from the thematic programme, in the interest of improving the quality and safety of their services.

Through its monitoring and inspection work, HIQA continues to see ample evidence that good leadership, governance and management in services is essential for building and sustaining effective and resilient services. This knowledge informed the approach of the Children's Team in its inspection and monitoring of children's residential centres and the regulation of the country's special care units.

Similarly, the focus of the 2019 inspection of Oberstown Children Detention Campus was on the leadership and governance and management arrangements in place for the use of restrictive procedures and the delivery of programmes to help the children understand and address their offending behaviour.

Compliance with the national standards on leadership, governance and management presented challenges for some of the services inspected. For example, there were

national variations in governance and management practices seen in children's residential centres. There were marked improvements across many of these centres to ensure that services were safe and effective. Nonetheless, the quality of key systems such as monitoring and oversight, quality assurance and risk management differed in a number of service areas and needed to improve. Risk management was not always fully understood and as a result, some centres could not benefit fully from the systems that were in place. While some centres had good quality assurance systems in place, they did not always result in improvements in practice.

Despite this, such findings do not necessarily mean that children experienced poor quality care in their day-to-day lives. Children provided inspectors with a rich picture of what was important to them and for the most part, children experienced being cared for in a way that made them feel valued and significant to those responsible for their care and development. Children who met with inspectors said they were aware of their rights and were encouraged and supported to exercise them. Family members were happy with the level of care their child received and they felt included in the decisions being made about their children.

However, good governance is intrinsically linked to good outcomes and experiences of people using services. It is critical to protecting and enhancing the good practice that is already in place. It also means that the individuals charged with the responsibility for the service are assured about its quality; that they are confident they can respond to identified risk and future challenges; and that they can consistently sustain an effective, child-centred and safe service.

In a well-governed service, the provider and managers do not lose sight of the fact that they hold the primary responsibility for the quality of the service and for demonstrating compliance with the relevant requirements; they are the first line of defence. This is one of the reasons we publish our inspection findings. We want to share the findings of our regulatory activity in a way that assists providers to inform their own quality improvement agenda in the interests of children and families who require their services.

Apart from individual inspection reports, one national overview report and four regional overview reports of Tusla services were published in 2019, with the aim of setting out key national findings and trends across service areas and regions. This was completed in the interest of improving the governance of these services and to support and inform the development of common systems and the consistency of practice at both local, regional and national level.

As ever, I wish to thank all the staff in the various services who assisted with the inspection and monitoring process in 2019. Finally I would especially like to thank all of the children and young people that we met and spoke with during 2019 and also

those that completed questionnaires to give us their views on different aspects of the services they received.

Mary Dunnion

Chief Inspector of Social Services and Director of Regulation,

Health Information and Quality Authority

1. Introduction to regulation and monitoring

About this overview report

This report sets out the overall findings of each of the various functions of the Children's Team. It also outlines how HIQA inspects and regulates: what children told inspectors during the course of the year; our engagement with informed and interested parties; and a concluding statement on our work undertaken in 2019.

Introduction to the work of the Children's Team

The Health Information and Quality Authority and the Chief Inspector of Social Services within the Regulation Directorate of HIQA, are responsible for regulating and monitoring the quality and safety of adult and children's health and social care services across Ireland. The Regulation Directorate fulfils its statutory obligations set out in the Health Act 2007 [(1)] (as amended) under the stewardship of:

- the office of the Chief Inspector of Social Services, which oversees the registration and regulation of designated centres for adults and children, such as (in the case of this report) designated special care units for young people
- the Director of Regulation, which is responsible for monitoring and inspecting the quality of service provided in social services, such as child protection and welfare services and foster care services, children's residential services and Oberstown Children Detention Campus.

This overview report outlines the Director of Regulation and the Chief Inspector's 2019 regulatory programme for services for children in need of care and or protection. It includes designated special care units and Oberstown Children Detention Campus.

It primarily sets out how in 2019 HIQA met its business plan objectives [(2)] in relation to children's services, including to:

- receive and assess all solicited and unsolicited information across children's centres and services and respond to risk in a proportionate and timely manner
- carry out phase 2 of a three-phase focused programme of monitoring of 11 of the 17 statutory foster care services to review the arrangements in place for:
  - the assessment of need for children in care
  - the care planning and review process, including preparation for leaving care, matching and safeguarding
- carry out a programme of inspection of one new private foster care service
- carry out a focused inspection of Oberstown Children Detention Campus by the end of the fourth quarter of 2019 to assess the leadership, governance and management arrangements in place in regard to:
  - the use of restrictive practices, and
  - the implementation of the centre's offending behaviour model
- deliver a programme of thematic child protection and welfare inspections
- carry out a focused programme of inspection of statutory children's residential centres to assess the leadership, governance and management arrangements in place at regional and local levels
- carry out four regional inspections of the supervision, care planning and review process in place for children placed in residential care
- carry out a programme of inspections of designated special care units
- issue notices of proposal for all designated special care units as required in response to a complete application for a new registration
- issue notices of proposal for all designated special care units as required in response to a complete application for a variation or removal of a condition of registration.

The full inspection reports of each service inspected in 2019 are available on the HIQA website: www.hiqa.ie.

2. How we regulate services

2.1 The statutory framework — monitoring against standards and regulations

The Regulation Directorate carries out three different types of inspections:

- inspections to check compliance with legally binding regulations, in the case of registered designated centres
- monitoring inspections which monitor ongoing compliance with specified nationally mandated standards
- thematic inspections which aim to promote quality improvement by focusing on national standards relevant to particular aspects of care and to improve the quality of life of people using services.

Each type of children's service has its own statutory framework that gives authority to HIQA and the Chief Inspector of Social Services to monitor the service using standards and regulations which set out what is expected from the service.

Table 1 on the following page shows the statutory framework for each type of service monitored by the Director of Regulation or regulated by the Chief Inspector.

Table 1. Statutory basis for inspection and monitoring of children's services by HIQA and the Chief Inspector

Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	National standards
Child Protection and Welfare Services	Inspected under section 8(1)c of the Health Act 2007 (as amended)	Health Act 2007 (as amended)¥ (1)		*National Standards for the Protection and Welfare of Children* (HIQA, 2012) (3)
Foster care services	Inspected under section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011	Child Care Act, 1991, as amended (4)	Child Care (Placement of Children in Foster Care) Regulations, 1995 (5) Child Care Placement of Children with Relatives) Regulations, 1995 (6)	*National Standards for Foster Care* (Department of Health and Children, 2003) (7)

Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	National standards
Special care units	Inspected under section 41 of the Health Act 2007 (as amended)[¥]	Health Act, 2007 (as amended)[¥]	Health Act 2007 (Registration of Designated Centres) (Special Care Units) Regulations 2017 (8) Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017 (9) Health Act 2007 (Care and Welfare of Children in Special Care Units) (Amendment) Regulations 2018 (10)	*National Standards for Special Care Units: November 2014* (published 2015) (HIQA) (11)

[¥] Number 23 of 2007: Health Act 2007 Revised: Updated to 8 January 2019. Health (Amendment) Act 2016. Dublin: Government Publication Office 2017. Available from: http://www.irishstatutebook.ie/eli/2016/act/6/enacted/en/pdf.

Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	National standards
Children Detention Units	Inspected under section 185 and section 186 of the Children Act 2001, as amended by Criminal Justice Act, 2006	Children Act, 2001 as amended by Criminal Justice Act, 2006 (12)		*Standards and Criteria for Children Detention Schools* (Department of Justice, Equality and Law Reform, 2008) (13)
Children's Residential Centres	Inspected under section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011	Child Care Act, 1991, as amended	Child Care (Placement of Children in Residential Care) Regulations, 1995 (14)	*National Standards for Children's Residential Centres* (HIQA, 2018)#(15)

On 7 November 2018, these standards replaced the National Standards for Children's Residential Centres, published by the Department of Health and Children in 2005.

2.2 Registration and Inspection activity 2019

During 2019, the Children's Team conducted 51 inspections of the various children's services under its remit.

This included inspections of statutory children's residential centres, private and statutory foster care services, child protection and welfare services, and Oberstown Children Detention Campus. Inspections were also carried out to assess compliance with the Child Care (Placement of Children in Care) Regulations 1995. Four inspections of designated special care units were carried out in order to monitor ongoing regulatory compliance.

Table 2. Inspection Activity 2019 by service and inspection type

Service type	Number of Inspections
Child Protection and Welfare – Risk based	3
Child Protection and Welfare – Thematic Programme	4
Special care unit – designated centres	4
Statutory foster care	11
Private foster care	1
Statutory residential care	18
Service area risk based inspection*	1
Child Care) Placement of Children in Care) Regulations 1995	8
Oberstown Children Detention Campus	1

* This inspection incorporated both child protection and foster care services.

2.3 Receipt of information

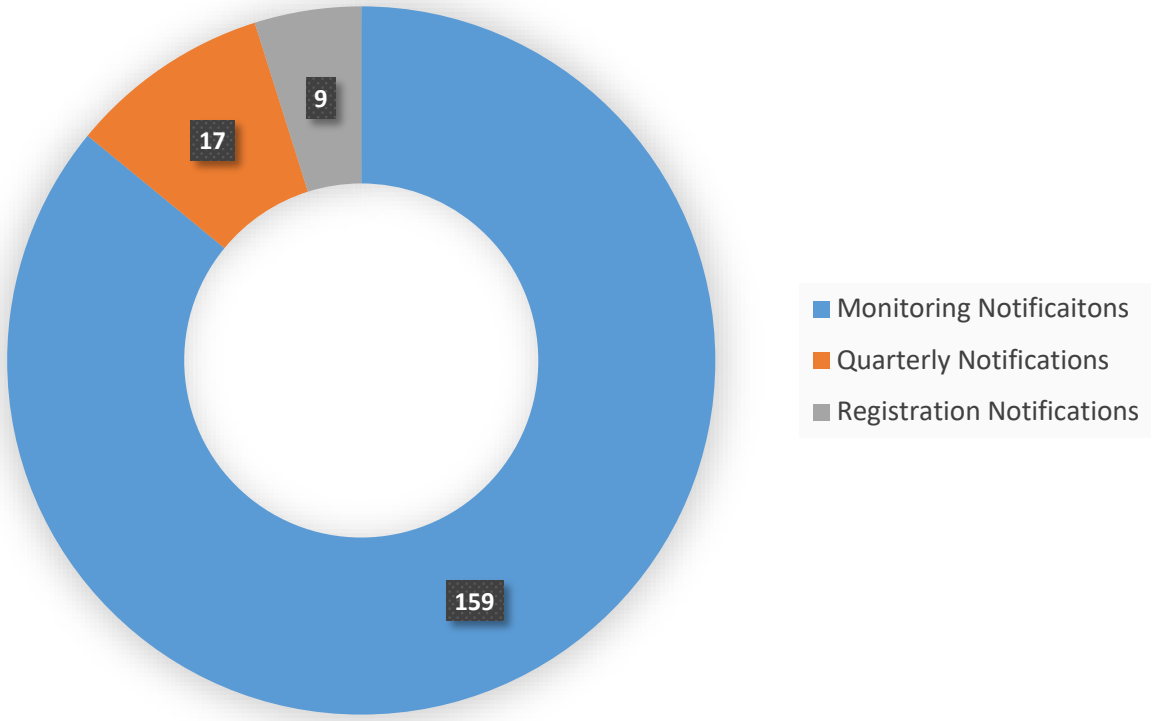
The Children's Team receives notifications from Tusla relating to designated centres for special care as well as non-regulated children's services. It also receives unsolicited information from people who have a concern about services provided to children.

2.3.1 Regulated children's services (special care units)

During 2019, the Children's Team received 185 notifications from Tusla relating to designated centres for special care. These are notifications that special care units are required to submit to the Chief Inspector within specified time frames.

The majority of notifications received in 2019 were those prescribed in the care and welfare regulations for special care units and they primarily related to issues such as absconscions, allegations of abuse and times when children were injured and required medical attention. Figure 1 below provides a breakdown of these notifications.

Figure 1. Notifications received from designated special care units by type of notification



2.3.2 Non-regulated children's services

Notifications of serious incidents involving children who are known to Tulsa's child welfare and protection services, including the deaths of children in care, are issued to HIQA's Children's Team by Tusla within 48 hours of the death or serious incident happening.

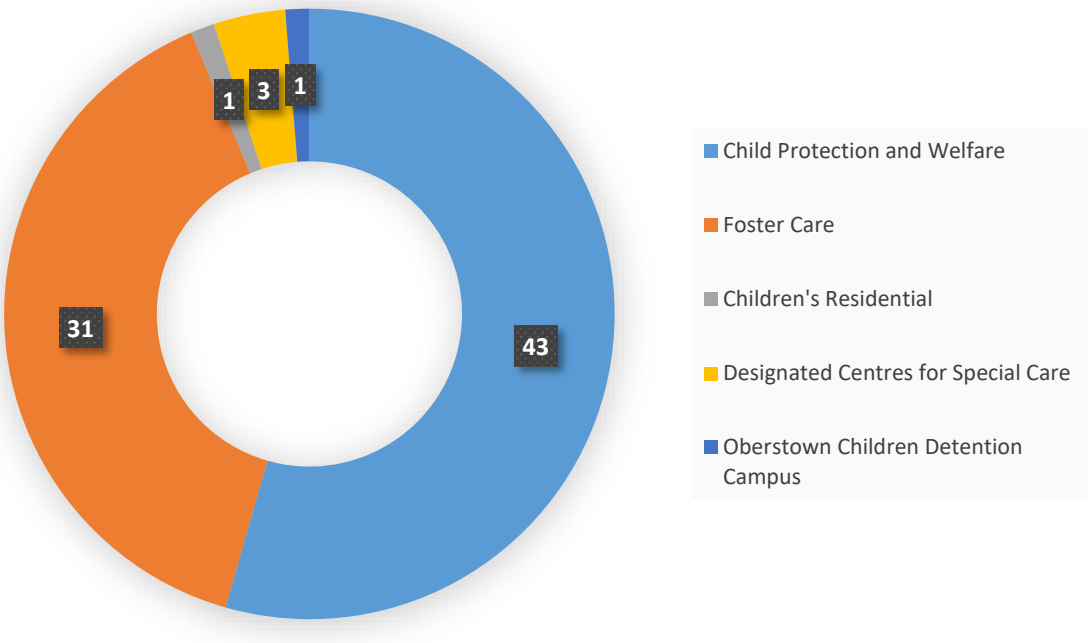
During 2019, the Children's Team received 28 notifications of serious incidents, including the deaths of children in care. Local reviews are carried out by Tusla following such incidents. These review reports are forwarded to HIQA once completed.

As with all information received, these reviews are risk assessed by HIQA and inform our regulatory activity in regard to the specific service area concerned. HIQA received 16 local review reports into such serious incidents from Tusla during the course of 2019.

2.3.4 Unsolicited information

During 2019, the Children's Team received unsolicited information from members of the public who had a concern about services provided. Unsolicited information is information which is not requested but is received by us. Figure 2 below shows the number of pieces of unsolicited information received by the Children's Team about the different functions we monitor, inspect and regulate.

Figure 2. Unsolicited information received by children's services



The Children's Team received 43 pieces of unsolicited information related to child protection and welfare services, 31 related to foster care, 3 related to special care units, 1 related to children's residential centres and 1 related to Oberstown Children Detention Campus. When we receive unsolicited information of concern in relation to services within our legal remit, it is reviewed by an inspector. This is done to establish if the information received indicates a risk to the safety, effectiveness, and management of a service for children and the day-to-day care and support provided to a child and their family.

It allows us to consider whether there are any trends or patterns that could indicate that something is happening in a service that falls outside of what is expected in the national standards, or what is required under the regulations. If HIQA considers that the service provider may not be compliant with the national standards or regulations as applicable, we can respond by:

- asking the service provider to submit additional information on the issue
- requesting a plan from the service provider outlining how the issue will be investigated and addressed
- using the information to inform what areas of practice we assess on inspection; and
- carrying out an unannounced inspection to assess the quality and safety and effectiveness of the service being provided.

Where the information indicates that children may be at immediate risk, HIQA will report the incident, in line with the Children First (2017) guidelines [(16)].

HIQA also receives information about services that are not within our remit. When this happens we may direct the person to the organisation best placed to address the complaint, the provider of the service, the Office of the Ombudsman or the Ombudsman for Children.

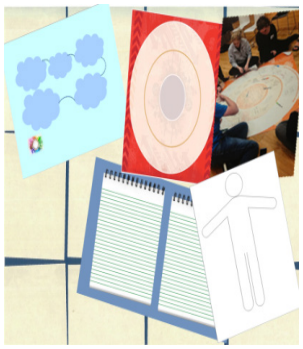
3. Amplifying children's voices

HIQA and in particular the Children's Team, has committed to further embedding how we promote and reflect the voice of children and young people in the work that we do. This includes expanding the ways in which we encourage and facilitate children and young people that we meet on inspections to participate.

By doing so, these children provide us with valuable insight into their direct experience of the services being inspected. A key focus of increased participation of children and young people in our work is to capture how they are involved in decision-making on issues that affect their lives. Children's right to participate in such decision making is enshrined in the Irish Constitution and Article 12 of the United Nations Convention on the Rights of the Child (UN, 1989) [(17)], ratified by Ireland in 1992.

During 2019, HIQA worked closely with Hub na nÓg, established by the Department of Children and Youth Affairs, to develop and deliver a training programme for HIQA inspectors on child participation. A two day workshop provided an opportunity for inspectors to focus on Article 12 of the UN Convention and the way in which the Lundy Model of Participation[¥], endorsed by the Department of Children and Youth Affairs, supports capturing the voice of children in an ethical and rights-based way.

As part of this workshop, inspectors examined and have since adopted, a range of methods to encourage participation by children, appropriate to the environments in which inspections occur. In large inspections, such as foster care, where inspectors meet children and young people across a range of ages and ability in group settings, they now have several consultation tools which use writing or drawing to enable children and young people to express their views on particular aspects of their care.



Some of these approaches include jotter pages and large sheets of paper with either clouds or giant circles, designed to help children and young people to communicate their thoughts and experiences on specific topics. Body maps, which are a simple body outline on a blank background, are also used to engage children to communicate their views both inside and outside the body line on issues such as the quality of communication between them and their carers.

[¥] Department of Children and Youth Affairs (2015). *National Strategy on Children and Young People's Participation in Decision-making 2015-2020*, Dublin: Government Publications

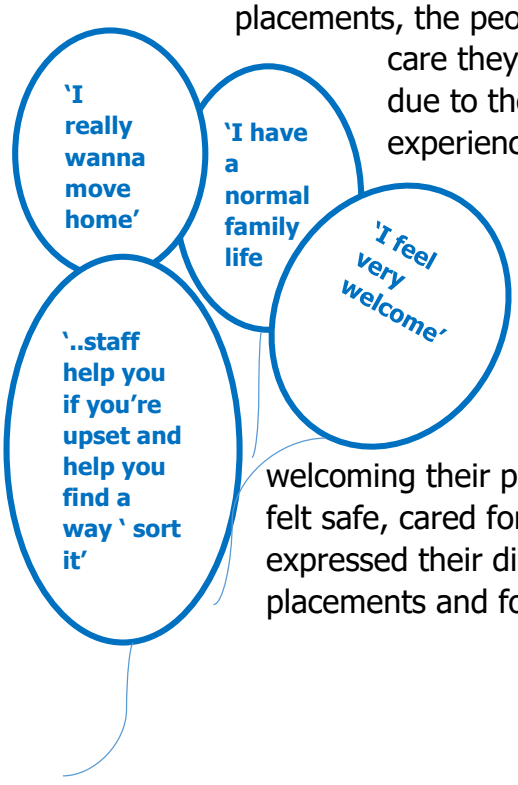
Sticky to-do notes are a particularly effective way of visually grouping written statements by children into themes, which can be explored further by inspectors. Children are encouraged to jot down their thoughts on certain questions on the sticky notes and group them together by theme. For example, on the top of a table or desk or wall space.

During 2019, the Children's Team applied the participative principles of the Lundy Model and the consultation tools provided, to its inspection processes for foster care, child protection and welfare, children's residential centres, special care and Oberstown Children Detention Campus. We believe the approach taken to seek and report on the voice of the children that we meet, was very successful in 2019 and remains so to date.

A new section dedicated to what children tell us about their care experiences was added to our report templates for foster care, children's residential centres and Oberstown Children Detention Campus during 2019. Over the course of the year, inspectors met or spoke with 256 children and young people in a variety of settings; comprising mainstream residential care (35 children), child protection and welfare (22), special care (11), foster care (176) and detention (12). These children were keen to express their views in several key areas, including their experience of their care placement, their inclusion in planning for their care and aftercare and their relationships and experiences with their social workers.

3.1 Care placements

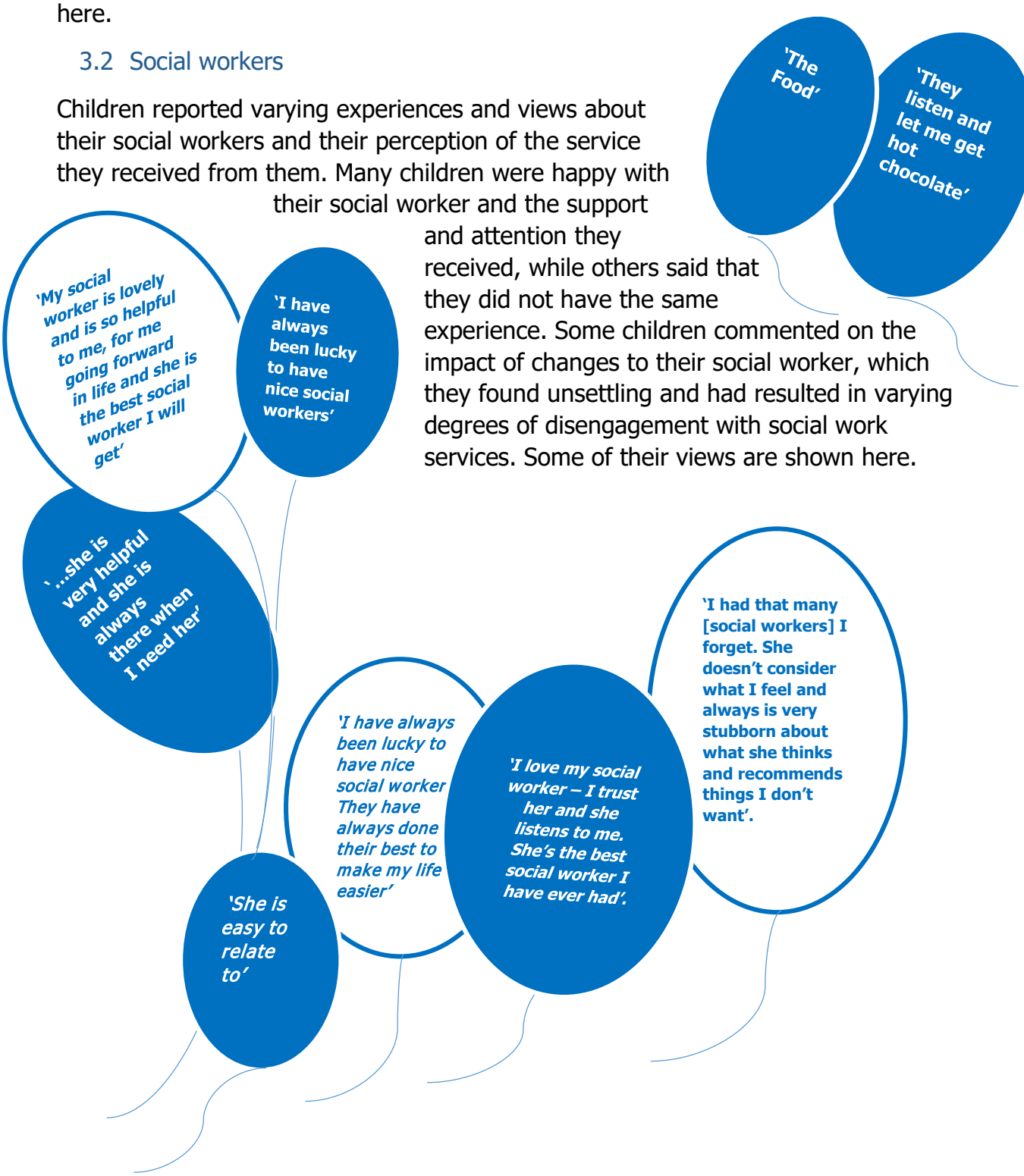
The children who engaged with inspectors during 2019 talked freely about their care placements, the people who were caring for them and the quality of care they felt they received. As one would expect due to the wide range of care settings, their experiences differed. Some children were placed in secure units, while others were in residential centres within local communities or were placed in foster care with already established families. Nonetheless, one common theme emerged across these different services; that is, how nice and welcoming their placements were and that many children felt safe, cared for and nurtured. However, children also expressed their dissatisfaction with aspects of their placements and for some, the fact that they were not



living with their families. Some of their comments (exactly as written) are illustrated here.

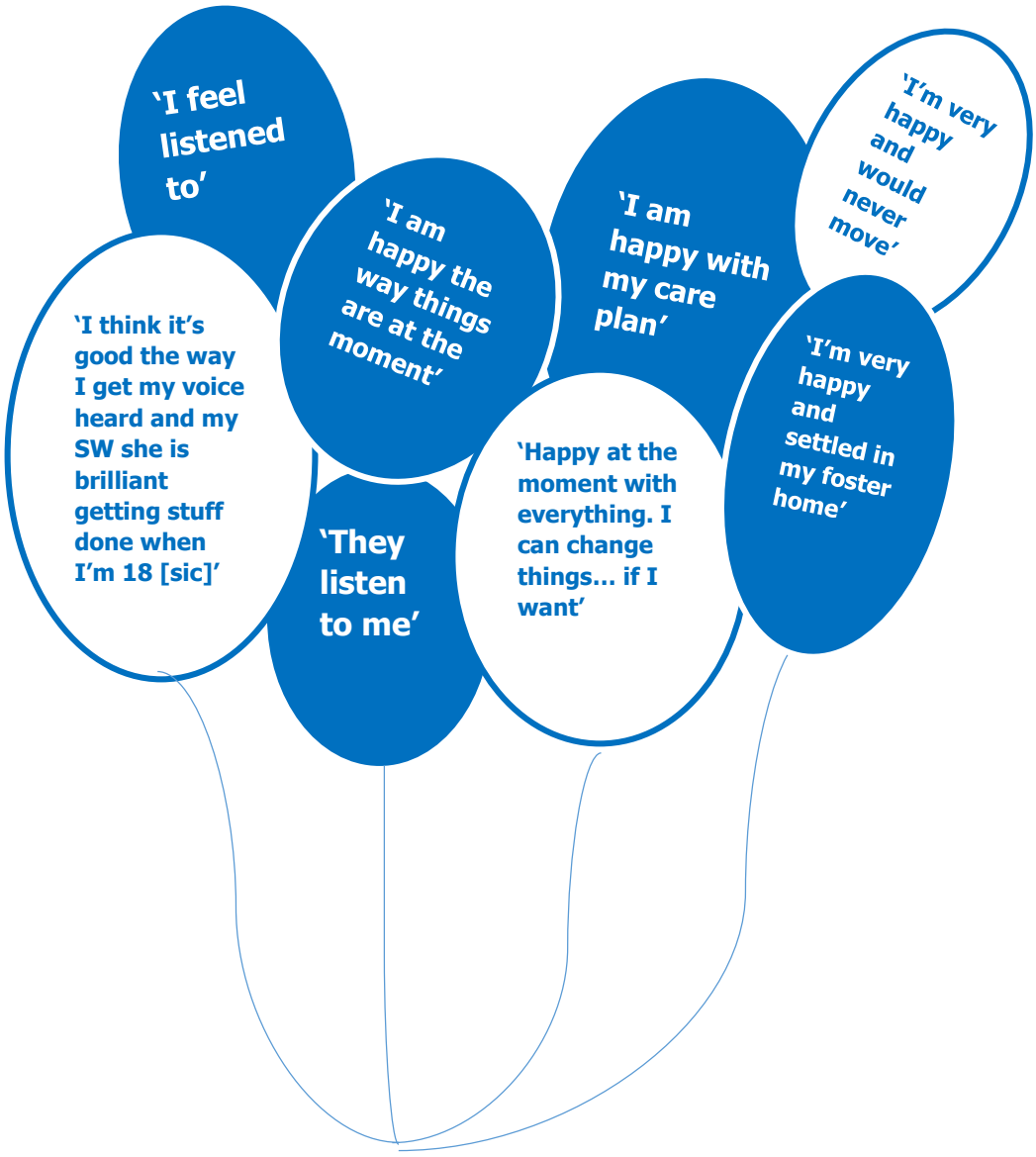
3.2 Social workers

Children reported varying experiences and views about their social workers and their perception of the service they received from them. Many children were happy with their social worker and the support and attention they received, while others said that they did not have the same experience. Some children commented on the impact of changes to their social worker, which they found unsettling and had resulted in varying degrees of disengagement with social work services. Some of their views are shown here.



3.3 Planning for their care

Most children told inspectors they were involved in planning for their care and were happy with their care plans. Many children described how they were supported to express their views and participate in decisions about their care. Children often said they felt listened to. A sample of their views are illustrated here.



However this was not the case for other children who described feeling unheard. Children often explained how it can be difficult to participate in the care planning process. Some feedback from the children is shown here.

3.4 Aftercare

The majority of young people spoke positively about aftercare services.

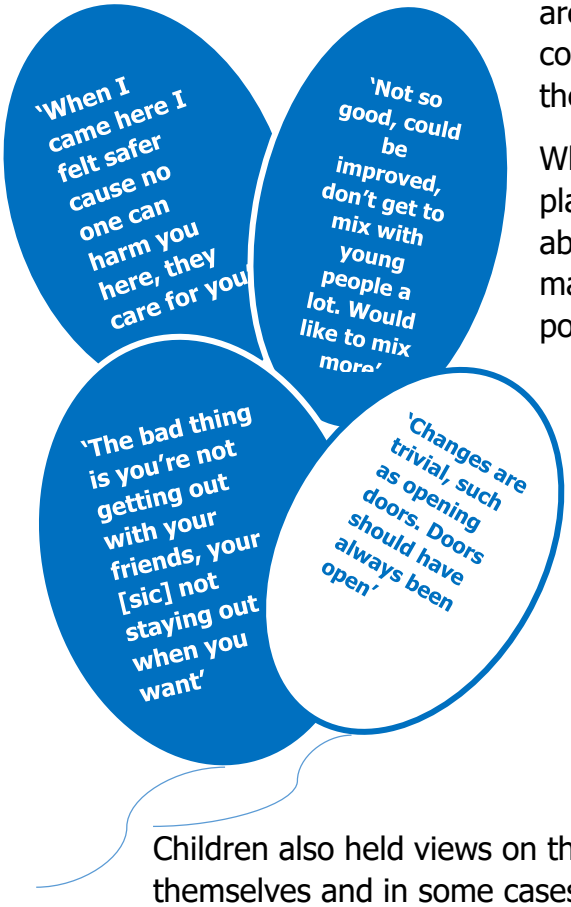
These young people described how aftercare workers supported them with independent living skills, housing, education and the significant positive impact this support had on their lives. The majority of young people described feeling listened to and said they were actively involved in planning for their aftercare. However, some young people also spoke about their fear of homelessness and needing more support in relation to their mental health. A small number of young people also spoke about how they did not receive any support from aftercare services. A sample of their views are illustrated here.

3.5 Secure care

HIQA inspects special care units where children are placed when it is determined that they need care and protection as their behaviour places them at risk. It also inspects Oberstown Children Detention Campus, where care and education is provided to children who have been committed to custody following conviction for a criminal offence or who have been remanded in custody while awaiting trial or sentence.

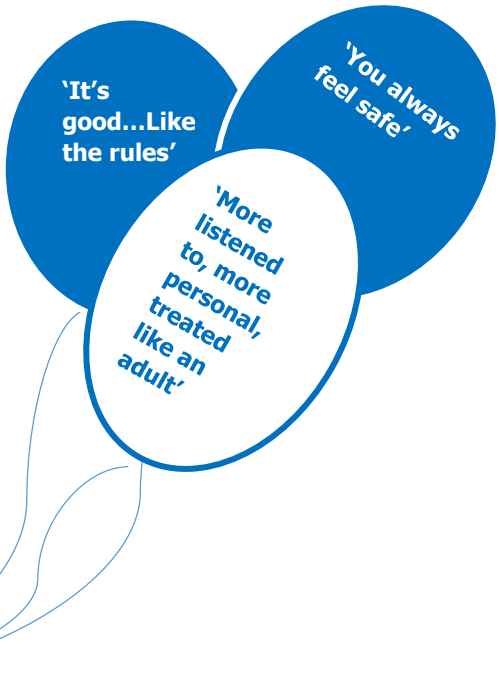
3.5.1 Special care

The Chief Inspector of Social Services regulates special care units. Special care units are secure (locked) units where children are placed by a court in response to the risk they may pose to themselves and or others.



While children who met with inspectors during their placements in special care units were not always happy about having been placed there, the overwhelming majority talked about how safe they felt. Children were positive about the support they received from staff members and were happy about the level of contact they had with their families.

They had insight into the purpose of their placements and why they were there and several found the limitations placed on them in a secure environment as comforting. Others felt that special care units should be more open inside, to allow for a less restrictive living environment.

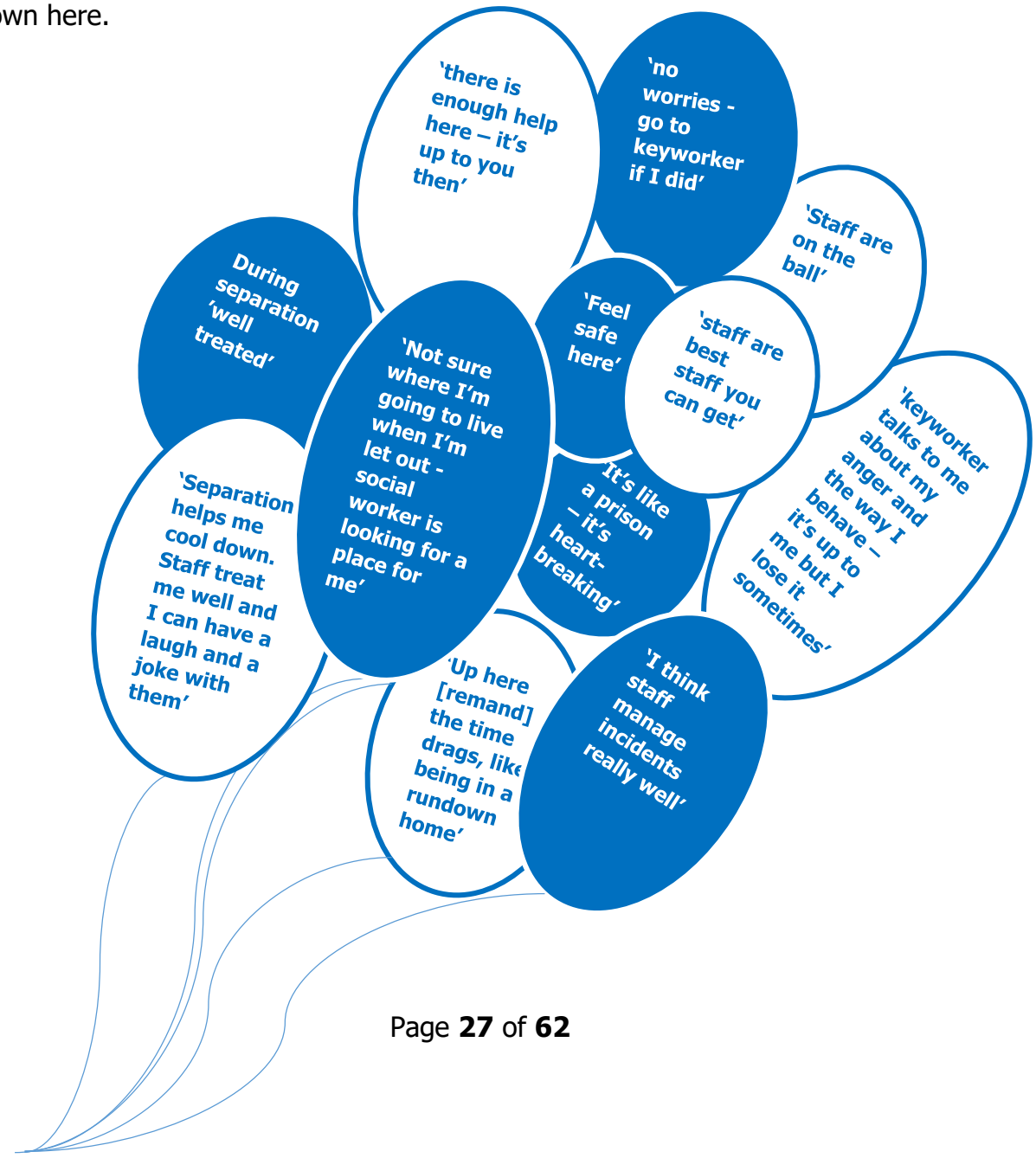


Children also held views on the special care buildings themselves and in some cases the building's lack of homeliness. Others talked about the impact of having their liberty taken away and the effect this can have, particularly on children who were used to making their own decisions on their lifestyles, and having very regular contact with their friends.

3.5.2 Detention

The inspection of Oberstown Children Detention Campus, focused specifically on the use of restrictive practices and the delivery of programmes to address offending behaviour. As such, inspectors sought the views of young people placed there on their experience of these aspects of the service.

All of the young people spoke positively about staff members and how effective they were at supporting them to make positive choices, particularly in relation to managing and understanding their feelings. They talked about restrictive practices, such as single separation and how they felt well looked after while separated from their peers. They also said that they understood why they were separated and that this approach helped them to calm down. Although the majority of young people were positive about their stay in Oberstown Children Detention Campus and the opportunities it provided them in particular to help break a cycle of offending behaviour and to manage their feelings in a better way, some were concerned about eventually leaving the campus and where they would live. Some of their views are shown here.



4. Child Protection and Welfare Services

HIQA monitors and inspects Child Protection and Welfare Services against the *National Standards for the Protection and Welfare of Children* (2012) [3]; the *National Standards for Foster Care* (Department of Health and Children, 2003) [7] ;the Child Care (Placement of Children in Foster Care) Regulations, 1995 [5] and the Child Care (Placement of Children with Relatives) Regulations, 1995 [6].

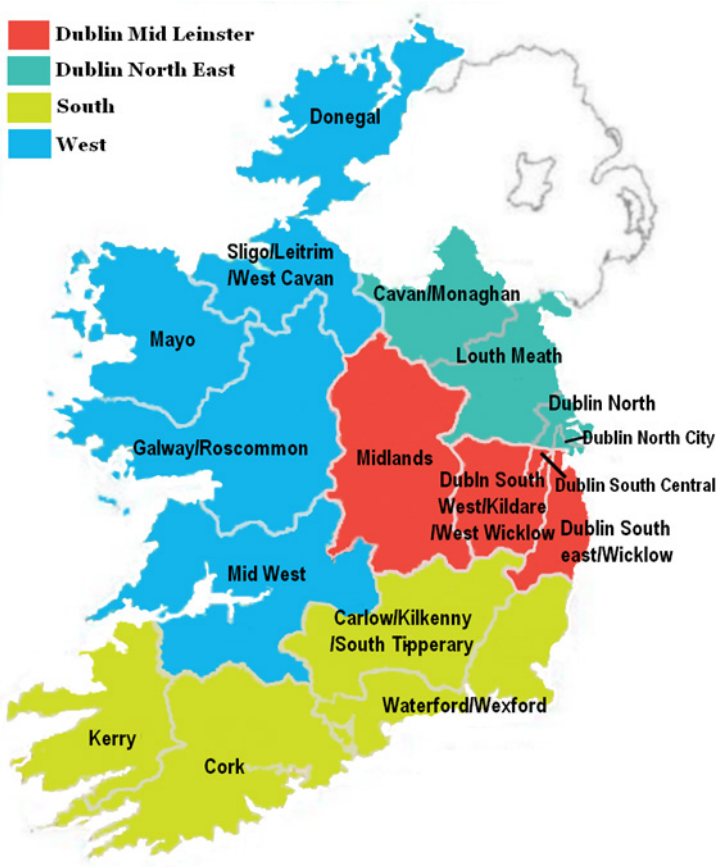
4.1 The role of Tusla

Tusla has statutory responsibility to protect children and promote their welfare under both the Child Care Act, 1991 [4] and the Child and Family Act 2013. [19] It does this by directly providing services and by funding other organisations to do so on its behalf. The primary functions of Tusla include:

- supporting and promoting the development, welfare and protection of children and the effective functioning of families
- offering care and protection for children in circumstances where their parents have not been able to, or are unlikely to, provide the care that a child needs. In order to discharge these responsibilities, Tusla is required to maintain and develop the services needed in order to deliver these supports to children and families and provide certain services for the psychological welfare of children and their families
- ensuring that every child in the State attends school or otherwise receives an education and for providing educational welfare services to support and monitor children's attendance, participation and retention in education
- that the best interests of the child guide all decisions affecting individual children
- consulting children and families, so that they help to shape Tusla's policies and services
- strengthening interagency cooperation to ensure seamless services which are responsive to children's needs
- undertaking research relating to its functions and providing information and advice to the Minister regarding those functions; and
- commissioning services child and family services on its behalf.

Child protection and welfare services are provided by Tusla in 17 service areas, located within four regions across the country (see Figure 3).

Figure 3. Tusla's service areas^



^ Map source: Tusla Website https://www.tusla.ie/

The Child Protection Notification System (CPNS) is a national electronic record of all children, who are assessed by Tusla, as being at ongoing risk of significant harm. Children placed on the CPNS have a child protection plan which is agreed at a child protection conference.

At the end of 2019, Tusla reported that all children on the CPNS[1] (876 in total) had an allocated social worker.[2] This has been a consistent finding since 2016, which indicates that Tusla continues to prioritise social worker allocation to

[1] A national record of all children who have reached the threshold of being at ongoing risk of significant harm and for whom there is an ongoing child protection concern, resulting in each child being the subject of a child protection plan (Children First, 2017).
[2] End of 2019 data provided by Tusla Quality Assurance Directorate February 2020.

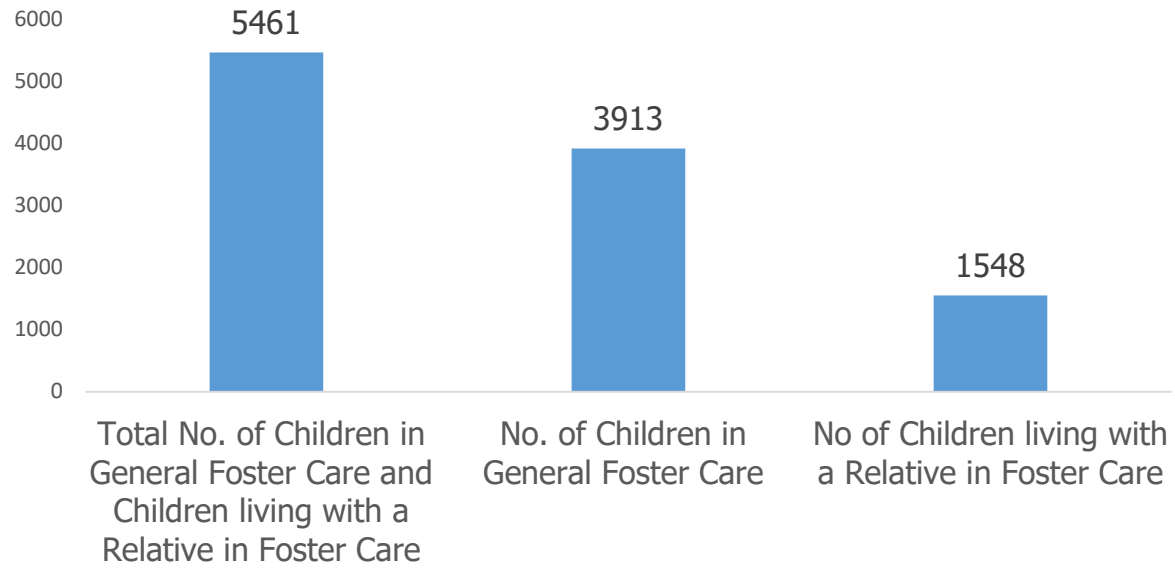
children who are most at risk.

At the end of 2019, the number of cases open to the child protection and welfare service was 24,827. Open cases are where referrals are either waiting for a service or are being actively worked on by Tusla. Of the total number of open cases, the number that were not allocated a social worker was 5,291. Of those, 653 were high priority cases.

Alternative care services refers to both residential care services and foster care services provided by Tusla, or the private and voluntary sector for children and young people, who are unable to live within their own families.

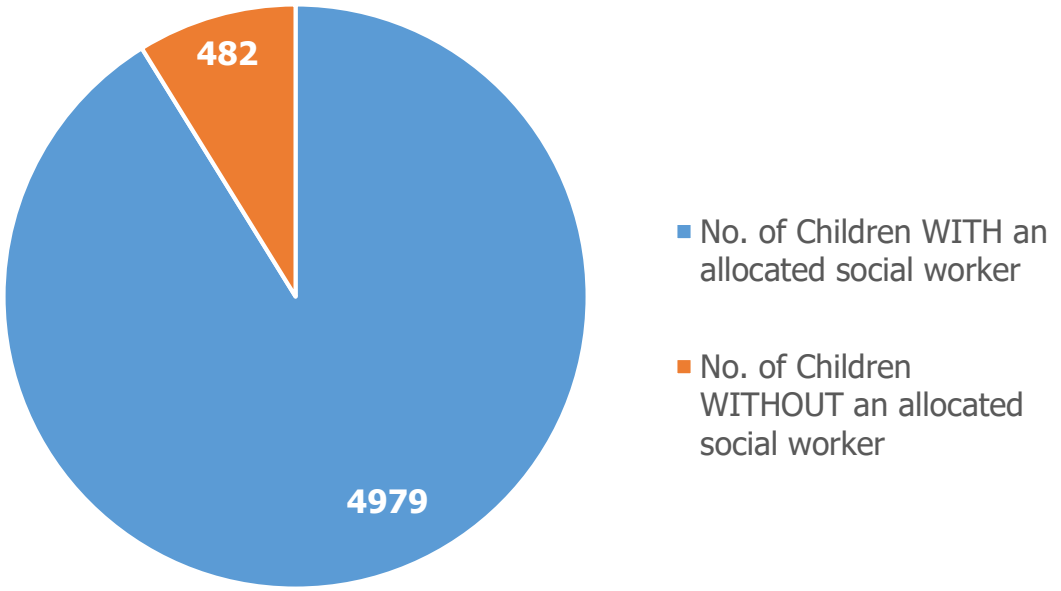
The highest number of children in alternative care placements were those living in foster care. The total number of children in foster care at the end of 2019 was 5,461. Of those, 1,548 were in foster care with relatives.

Figure 4. Number of children living in general foster care and living in foster care with a relative at the end of 2019



As can be seen, more than seven out of ten children (over 71%) in foster care are in general foster care. That is to say, they are living with foster carers who are not members of their extended family. In contrast, nearly three out of ten children in Ireland (over 28%) who are in foster care live with a family relative who is also their foster carer. Figure 5 below shows the breakdown of all foster children who have and do not have an allocated social worker.

Figure 5. No. of children living in foster care with/without an allocated social worker



As illustrated at the end of 2019, 482 out of 5461 children living in foster care did not have a named social worker allocated to their case.

4.2 Child protection and welfare – monitoring and inspection activity

4.2.1 Thematic child protection and welfare programme

HIQA's child protection and welfare thematic inspection programme, which HIQA developed in 2019, was primarily focused on defined points along a pathway in child protection and welfare services provided by Tusla: from the point of initial contact or reporting of a concern to Tusla through to the completion of an initial assessment.

This programme arose out of a commitment made by HIQA in its 2018 report: *Report of the investigation into the management of allegations of child sexual abuse against adults of concern by the Child and Family Agency (Tusla) upon the direction of the Minister for Children and Youth Affairs.* [20] This investigation was carried out at the request of the Minister under section 9(2) of the Health Act 2007 (as amended) and had looked at the management by Tusla of child sexual abuse allegations, including allegations made by adults who had alleged they had been abused when they were children (these are termed retrospective allegations).

The investigation specifically reviewed how Tusla had managed child sexual abuse allegations. This HIQA thematic inspection programme is broader in scope because it assesses Tusla's management of all child protection and welfare referrals and reports received, rather than management of allegations of child sexual abuse referrals only, which had been the focus of the investigation. However, it does incorporate a review of two out of three of the systematic risks identified by the Investigation Team in 2018, namely; screening and preliminary enquiry of referrals and safety planning.

The aim of the thematic programme is to promote and support quality improvement in the management of child protection and welfare referrals from receipt of the report by Tusla social workers, following a pathway through screening and preliminary enquiry, safety planning and the completion of an initial assessment. Services are assessed against seven of the *National Standards for the Protection and Welfare of Children* (2012) [(3)].

The work of the child protection and welfare thematic project team, started with researching the relevant child protection literature in October 2018. The draft review of literature was completed and an external advisory group was brought together by HIQA for consultation and comment on the proposed programme. This group comprised representatives from the Child and Family Agency (Tusla), the Department of Children and Youth Affairs, Barnardos, Epic (an advocacy organisation for children in care and care leavers), Trinity College Dublin and the Director of People (Children and Adults), Medway Council in the UK.

The external advisory group met on two occasions in February and March 2019. It was also consulted when required and it provided feedback throughout the programme's development phase on the review of the literature and the proposed methodology of the inspection.

As part of the development of the thematic programme, consultations with parents and children were organised in June and July 2019 to hear their views on how HIQA should involve parents and children in the thematic programme of inspections that were planned. We consulted separately with the children and their parents. Their feedback, along with the feedback from the Expert Advisory Group, helped inform the final guidance assessment-judgment framework for the programme [(21)]. Assessment-judgment frameworks are guidance documents to assist us with checking compliance against regulations and or standards. They can also be used by providers to self-assess their own service.

In August 2019, a meeting was organised by HIQA to present the child protection and welfare thematic programme and methodology to representatives from Tusla service areas.

One of the tools used in the inspection programme is a self-assessment questionnaire which providers must complete and return to HIQA. The self-assessment questionnaire was initially issued to 12 service areas in Tusla and a copy of each area's self-assessment was returned to HIQA for review. These questionnaires along with Tusla's published data on unallocated cases, informed the schedule of inspections. As the focus of these inspections is quality improvement, HIQA focused initially on those service areas that had either low or no levels of children waiting for a service. This was with a view to sharing best practice with other areas that may not be doing well in this key area.

This thematic inspection programme started in October 2019 and four inspections were completed by the end of the year. The remaining seven service areas will be inspected during 2020. The first inspection report, published in December 2019. outlined that at the time of inspection, a proactive and responsive child protection and welfare service had been delivered in the Tusla Mayo Service Area, from the point of the initial reporting of a concern to Tusla through to the completion of an initial assessment. Management ensured that there were no children waiting for a service and assured themselves that social workers undertook good quality and child-centred with children and families.

The five service areas that are not included in the thematic programme are currently subject to service improvement plans developed by Tusla, as a result of risk which it had itself identified related to these service areas. Progress in regard to these improvement plans, will be reviewed by the Children's Team in 2020, and the findings may lead to further regulatory activity by HIQA if appropriate.

4.2.2 Risk-based child protection and welfare inspections carried out in 2019

The Children's Team routinely receives and reviews notifications of: serious incidents, or deaths of children known to Tusla; unsolicited information received by HIQA and data published by Tusla in relation to its child protection and welfare services. Following a review of information received by the Children's Team, four risk-based inspections were carried out during 2019. One of these inspections was part of a service area inspection, which inspected both the child protection and foster care services. Two of the service areas involved had a risk-based inspection previously, in 2017 and 2018 respectively, and the 2019 inspections followed-up on their progress since that time.

The risk-based child protection and welfare inspections focused primarily on how Tusla responded to and managed new referrals of concern about a child. At the time of inspection, all four service areas had substantial numbers of children waiting for a service, which included some children who had been classified by Tusla as high priority.

Three inspections followed the entire referral pathway from the receipt of a concern to the point of completing an initial assessment. One inspection focused specifically on the initial response of Tusla to a new referral, known as the screening and preliminary enquiry stage and the arrangements for keeping children safe (known as safety planning).

4.3.3 Key findings of child protection and welfare risk-based inspections

The following sections describe HIQA's findings in relation to its assessment of the management of referrals as part of its child protection and welfare inspections.

Screening and preliminary enquiry

Screening is the first step taken by a social worker in managing a referral. It involves evaluating the referral made for a child or family to assess whether it is an appropriate referral to its child protection and welfare service.

Effective and timely screening is necessary to provide social workers with enough information to inform their decision on what action is required to progress with the referral and importantly, to protect children at immediate risk of harm.

Tusla has a 24-hour time frame within which this kind of screening should take place. These inspections found that this time frame was being met by two of the inspected service areas in most cases, but improvements in the timeliness and quality of screening was required in the other two areas.

Preliminary enquiry refers to the process of bringing together and analysing all information, gathered during the early stage of managing a referral, to inform decision-making. This information is recorded by Tusla on a standardised form known as an intake record.

Tusla has a time frame of five working days during which a referral should be screened and a preliminary enquiry completed. HIQA used Tusla's standard business process to identify five key quality indicators which were then used by inspectors to assess the overall quality of screening and preliminary enquiries. These quality indicators were as follows:

- completed within five working days
- classification appropriate
- internal checks carried out
- details clarified with the referrer
- priority-level appropriate.

Although the overall quality of screening and preliminary enquiries in the two service areas previously inspected had improved, none of the four service areas met the five-day time frame for their completion. Furthermore, inspectors identified that delays in both the start and the completion of preliminary enquiries ranged from days to months.

Nonetheless, inspectors found that during the screening and preliminary enquiry phase, cases had been correctly classified into categories of abuse or welfare, while the priority levels assigned to them had been largely accurate. While internal checks were completed to identify if a child had already been known to Tusla social work services, there was inconsistent practice across all four service areas around checking the details of referrals with referrers.

According to Tusla's own processes, each child protection and welfare referral should have its own preliminary enquiry, as this ensures information on all historical referrals is considered when assessing the level of risk to, or needs of a child, whenever subsequent or multiple referrals are received. In 2019, this did not always happen in one service area inspected and posed a potential risk to children.

Initial assessment

An initial assessment is completed to identify the level of unmet need and or risk to a child and it supports social workers to determine what steps are required to meet these needs and safeguard the child involved. It may identify for example, that a child is at ongoing risk of significant harm, which requires a particular protective response.

Three inspections followed the entire referral pathway from the receipt of a concern to the point of completing an initial assessment. There was a noted improvement to

the quality of initial assessments in the two services areas previously inspected in 2017 and 2018. These improvements included children being seen routinely as part of the assessment process and parents being consulted. There was evidence of the analysis of risk and better consultation with health and or social care professionals.

However, improvements were required across all three service areas where initial assessments were reviewed, to ensure these assessments were being undertaken promptly and in line with Tulsa's own standard business process. It was of concern to inspectors that in the third service area, not all children were met with by social workers or social care workers as part of the initial assessment process. This finding was not in line with good practice.

Waiting lists and waiting list management

Children were waiting for a child protection and welfare service in all four service areas inspected in 2019. Waiting lists were in place in three of the areas for preliminary enquiries to be completed and substantial waiting lists existed in all four areas for an initial assessment, 101,201,269 and 415 respectively. Inspectors reviewed how these waiting lists were being managed to reduce their volume and ensure the risks to children did not escalate without an appropriate response.

There was no national approach being taken by Tusla to manage waiting lists for children and families awaiting a service from Tusla and this resulted in variance and a lack of consistency within the areas inspected. However, inspectors found evidence of a number of local initiatives being rolled out to appropriately divert some referrals to more appropriate welfare services.

One area had no system in place to formally review cases awaiting preliminary enquiry. Another had developed a local policy to guide practice, but inspectors found that the quality of reviews of waiting list cases was mixed. Although waiting lists were reviewed in a third area, the approach taken differed between offices and managers. The fourth area had developed a common approach to managing these cases, but staffing resources coupled with a backlog of cases impacted significantly on its ability to manage waiting lists effectively and to ensure that the interventions to keep children safe were timely. Tusla has subsequently issued guidance to its service areas in relation to the waiting list management in order to have a consistent approach.

Three areas had completed some re-structuring of their child protection teams shortly before HIQA's on-site inspection fieldwork was carried out. While this had been at different stages of implementation at the time of the inspections, there were some indications that it was starting to have a positive impact on the timeliness of screening new referrals.

In addition, all four areas had taken some action to try to appropriately divert some referrals away to its welfare services from its child protection services. For example, one service area was allocating low priority cases to a social care leader to carry out a preliminary enquiry, under the supervision of a social work team leader. This area was also assigning responsibility for areas such as domestic violence to specific staff. Across all four service areas, Review Evaluate Divert (RED) teams were routinely used to divert cases to welfare services.

Safety plans

Safety planning refers to the arrangements put in place by Tusla to enable children at risk of harm or abuse to be safe. The review of safety planning in these risk-based inspections was confined to children who were waiting for a preliminary enquiry to be completed, who were awaiting an assessment, or who were not allocated to a social worker.

In July 2019, inspectors were informed that a national guidance document on safety planning was due to be implemented by Tusla. The need for such guidance to ensure safety planning was embedded in social work practice was borne out by inspection findings, as this had not been happening in those areas inspected. Safety planning varied across and within these areas. By way of example, when safety plans were required, they were not always drawn up in a timely and consistent way. Furthermore, the quality of safety planning varied within service areas, as some children had comprehensive plans while others had none, or those in place were deemed by inspectors to be inadequate.

Notification of suspected abuse to An Garda Síochána

These inspections found that in three out of the four service areas inspected, improvements were required to ensure a consistent understanding of the requirements for notifications to An Garda Síochána of suspected crimes of wilful neglect or physical or sexual abuse against children, and the requirement to do so in a timely manner.

Governance arrangements

Despite evidence of some practice and local initiative in those services inspected, an overarching finding of the four child protection and welfare risk-based inspections in 2019 was that improved systems of governance were necessary in those service areas to ensure a consistently safe and timely service for all children appropriately referred to Tusla.

There were some examples of good practice in the four areas inspected. They included the measures in place to divert families to external services where a welfare

response was more appropriate. There was also good interagency working between Tusla and An Garda Síochána, particularly where children were deemed to be at immediate risk.

Inspectors found examples of immediate action being taken to protect children at immediate risk of harm. In these cases, effective safety planning was in place, good interagency cooperation was seen and there was diligent managerial oversight of practice. Overall, in the longer term, when children had an allocated social worker, most children received a good service.

Nonetheless, improved systems of governance were necessary to ensure a safe and timely child protection and welfare service for all children referred in those four services areas inspected during 2019. During 2019, Tusla was in the process of implementing significant systems changes.

A specific approach to practice was being implemented nationally, and a National Child Care Information System (NCCIS) was being rolled out across the country. At the same time, the recruitment and retention of staff remained a challenge for most of these four service areas. This impacted on their ability to meet the demands placed on their services, as well as managing existing waiting lists.

The risk-based inspections did not focus on workforce planning and resource management, but common areas which required improvement were evident across all four service areas inspected. They included the need to:

- share learning throughout Tusla
- consistently implement policies, procedures and standard business processes
- strengthen managerial oversight of staff practice, including staff supervision
- consistently implement caseload management systems, and
- strengthen the systems in place for identifying and managing risk.

All four service areas provided action plans to address the specific non-compliances identified by inspectors. In addition, Tusla put service improvement plans in place for five service areas, three of which were among those areas which had a risk-based inspection. Most actions set out in the service improvement plans were due for completion by the end of December 2019. HIQA will continue to review the progress in these Tusla areas during 2020.

7. Alternative care services

Alternative care services refers to both residential care services and foster care services provided by Tusla or the private and voluntary sector for children and young people who are unable to live within their own families. HIQA monitors and inspects

the 37 statutory children's residential centres provided by Tusla, and both statutory and private foster care services.

7.1 Tusla social work services provided to children in residential care

In the first half of 2019, the Children's team focused on the statutory duties of Tusla social workers to monitor placements of children in care, in line with the Child Care (Placement of Children in Care) Regulations 1995. These inspections were announced and covered regulations 22 to 25, which relate to: social work case records, care planning, supervision and visiting and case reviews of children placed in residential care.

Eight inspections were carried out using a regional approach. HIQA inspected two service areas within each of the four Tusla regions: the West, the South, Dublin North East (DNE) and Dublin Mid-Leinster (DML). The identification of service areas for inspection was informed by an analysis of Tusla's published data on how it was performing in relation to care planning and reviews, and the allocation of a social worker to children in care. To ensure balance, a mixture of service areas that had been performing well and those where metrics indicated a need for improvement, were chosen for inspection. Four regional reports on inspection findings were published.

Overall, these inspections found that each Tusla region was either compliant or substantially compliant with all four regulations, with the exception of DML, which was moderately non-compliant with the regulation related to supervision and visiting of children in care. HIQA was assured that the necessary actions would be taken by DML to improve its social work services to children placed in residential care and these actions were outlined in an action plan submitted to HIQA by the region.

7.1.1 Care planning and review for children in residential care

These inspections found that care planning was generally good for children in residential care. Care plans were found to be comprehensive and up to date. They included all the necessary elements of a good care plan, including an outline of the child's individual needs and the supports they required, as well as arrangements for contact with their families. It was evident that children, their families and other professionals were included in the planning process and written care plans captured these views.

The regulations require children care plans to be reviewed within specific timescales, depending on the age of the child and their level of need. Independent chairpersons

were in place in the West region to chair these reviews and this worked well. Reviews were undertaken in a timely manner across three of the four regions. In the DML region, most care plans were reviewed regularly and in some cases, more often than required by the regulations. Where delays existed, these delays were linked with the sensitive nature of factors surrounding an individual child, or placement issues. Children often attended their review meetings, and when they chose not to do so, they were supported to make their views known.

In addition to these generally positive findings, a care planning initiative taken by the Dublin North East Region merits wider consideration for implementation across other service regions. The region had developed a summary care plan, which was a colourful, graphic presentation of the key elements of a care plan. This design assisted children and those with learning difficulties or complex needs to visualise the plan and information given to them.

Some areas of improvement across all four regions in relation to care plans and their review included the need for timely approval of care plans by social work team leaders and consistency in the quality of information held in care plans. Sharing of decisions made at child-in-care reviews could be better to ensure all parties involved in delivering care to the child were clear on their individual roles and responsibilities.

7.1.2 Supervision and visiting

Supervision and visiting of children in residential care was generally good and records of these visits were held by social workers. Although the majority of children placed in residential care at the time of inspection were allocated a social worker, it was evident that there had been periods of time during their stay in State care when some children had not been allocated a social worker.

In the eight inspections, the majority of children were visited within the time frames set out in the regulations, but also in response to risk or their level of need. The quality of visits undertaken was clearly recorded on each child's case record and they typically reflected child-centred practice and the purpose of the visit. They demonstrated the positive relationships that had been established with children.

However, in the South region there was inconsistent practice in relation to where and how records of visits were recorded and this meant they were not always easy to find. In the DNE region, inspectors found that not all children had an allocated social worker as required by regulation. In the DML region, although some children were visited more often than was required, others were not visited within the required time frames set out in the regulations. In addition, social work records of visits cross all four regions did not always hold an account of the work conducted by social workers during these visits.

7.1.3 Case records

The regulations require that Tusla maintains in perpetuity (forever) a case record for every child placed in residential care. These records should hold specific information, such as the child's date of birth, medical history and their care planning documents. These inspections found that although each child placed in residential care across the four regions had a case record, they varied in quality and in the time frames within which they were required to be updated.

While compliance levels were generally good, written assurances were sought from the DNE region in relation to keeping voluntary care arrangements up to date and in the DML region, case records did not consistently hold all information required by the regulations.

7.2 Statutory children's residential centres

In the second half of the year, the team completed phase two of its inspections of Tusla services for children placed in residential care. It carried out 18 inspections of children's residential centres run by Tusla.[≠] The team ensured a representative sample of centres within each Tusla region was inspected for the purpose of learning and driving continual improvement at local and regional levels. Two of the centres included in this schedule of inspections were prioritised due to poor findings in 2018, specifically, the premises from which the services were being delivered.

This was the first time that these centres level of compliance was assessed against the *National Standards for Children's Residential Centres*, which were approved by the Minister for Children and Youth Affairs and published by HIQA in 2018. As part of our preparation for children's residential centres becoming regulated centres under the Health Act 2007 (as amended), inspections focused on 12 of the 29 national standards relating to leadership, governance and management and the delivery of needs-based care to children in a safe and effective way.

The findings of these inspections are presented under the headings of 'capacity and capability' and 'quality and safety'. Capacity and capability describes the leadership and management of the service and how effective it is in ensuring that a good quality and safe service is being sustainably provided. It outlines how people who work in the service are trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service. Quality and safety describes the care and support children receive and whether it is of a

[≠] The number of Tusla provided children's residential centres fluctuated between 36 and 39 in 2019. It remains at 37 at time of preparing this report.

good quality and ensured children were safe. It includes information about the care and supports available for people and the environment in which they live.

Overall, these 18 inspections found that children were well cared for and the majority experienced nurturing and safe care. However, a minority of children had complex needs which could not be met within the centres inspected and for some, onward placements which could meet these needs were difficult to source. This meant that for some children, their experience of care at times was neither safe nor pleasant. In these circumstances, HIQA liaised with both centre managers and Tusla social workers and managers to ensure all necessary measures were taken to safeguard these children and those who shared their placements with them.

The overwhelming majority of children placed in the children's residential centres inspected had an allocated social worker, who visited them regularly and organised their child-in-care reviews. There was evidence of good coordinated care between centre staff and social work departments. However, this was not the case for a small number of centres, where there were delays in providing minutes of child-in-care reviews to the residential centre. Although this did not impact negatively on these children's care, it meant that the plans put in place by centre staff to meet these children's needs were not informed by an updated care plan in a timely way.

There were many examples of good practice in relation to systems of reporting and managing child protection concerns and where there were delays, a rationale was clearly recorded in centre records. However, poor access to electronic record-keeping systems posed a challenge in some residential centres. This meant that some staff were unable to submit child protection concerns through Tusla's electronic portal. These issues were being addressed over the latter half of 2019 by Tusla.

Children's rights were well promoted and children who met with inspectors said they were aware of their rights and were encouraged and supported to exercise them. The members of children's families, mostly one or other of their parents, who met with inspectors or who talked with inspectors by telephone, were happy with the level of care their child received and they felt included in the decisions being made about their children.

Leadership and governance and management practices varied across the country. There were marked improvements across many centres to governance systems which ensure services are safe and effective. However, key systems such as monitoring and oversight of practice, staff supervision, quality assurance and risk management differed and needed to improve.

While some centres had good quality assurance systems in place, they did not always result in the changes to practice which were required to show improvements.

Inspectors found evidence that risk management was not always fully embedded in some centres and as a result, these centres had yet to benefit from the risk management systems in place. Tusla must address such challenges in the delivery of safe services into the future.

HIQA inspections of children's residential services did not find any centre which was under-resourced in terms of staffing at the time of inspection. While agency staff were regularly used in some centres, they were consistent members of the staff team and were familiar to the children placed in these centres. Recruitment was ongoing throughout the year and some centres had benefited from new staff being appointed. There were some centres with managerial posts filled on an interim basis and although they were being managed well, interim positions at this level do not provide service stability in the medium to long term.

7.3 Foster care – statutory

Introduction to inspection of statutory foster care services

In 2017, the Children's Team commenced a three-phase focused programme of inspection of statutory foster care services in 17 Tusla service areas. The first phase (2017-2018) focused on 'the recruitment, assessment, approval, supervision and review of foster carers, including the arrangements in place for safeguarding and child protection of children in foster care placements'.

Phase 2 of this programme started in 2019, and focused on six of the national standards for foster care:

- the child and family social worker
- assessments of children and young people
- care planning and review
- matching carers with children and young people
- safeguarding and child protection
- preparation for leaving care and adult life.

In essence, the focused inspection programme examined whether the child in foster care had an allocated social worker; the extent to which their needs were assessed prior to or as soon as possible after placement; whether the child's care was subject to a formal process of planning and review, including preparation for leaving care; that the child was matched with foster cares that could meet their needs; and that systems were in place to safeguard and protect the child.

Conducting these inspections involved:

- analysing data submitted by service areas and questionnaires completed by children in care and young people in aftercare
- meeting with or speaking to children and young people availing of the aftercare service
- interviewing and meeting with the area managers, principal social workers for the children-in-care teams, the foster care teams and aftercare managers
- visiting foster care households and meeting with the children living in these homes
- holding separate focus groups with children-in-care social workers and child protection social workers, fostering social workers, team leaders for the long-term children-in-care team, aftercare workers and foster carers
- reviewing the relevant sections of children's case records as they related to the theme of the inspection, and
- phone calls by inspectors with parents of children in care, foster carers and children in care.

Findings from 2019 inspections of statutory foster care services

By the end of 2019, inspections had been completed in 11 service areas, with the remaining six inspections due for completion in 2020. Inspectors visited 72 foster care homes and met with 176 children in foster care. Inspectors also met with or spoke with foster carers and parents as part of our inspection activity. Over 600 questionnaires were received from children in care, the majority of which were received by post, about their experience of the foster care service.

These inspections found that when children were allocated a social worker, they received a good quality service, and children spoke very positively about their social worker. Social workers visited children and met them on their own, in line with the standards. All children in three of the 11 areas had an allocated social worker, while a fourth area had only four unallocated children in care. Some areas had significantly high numbers of unallocated children in care and as a result, these unallocated children were not receiving a good quality service and were not being visited in line with the regulations. Each of the four areas had over 60 children in care that had not been allocated a social worker, and the remaining three areas had between 20 and 30 children without an allocated social worker.

Of significant concern was that two areas had a small number of dual unallocated cases, whereby neither the child nor the foster carers had an allocated social worker.

The remaining nine areas however, had taken steps to ensure that there were no dual unallocated children in care in their areas.

Assessments of children were comprehensive, multidisciplinary when required and assessed all required areas of a child's needs. Matching of children to carers who had the capacity to meet their assessed needs was evident in the majority of areas; however, there were backlogs in completing long-term matching in several areas.

Some of the improvements noted by inspectors included an improvement in the oversight and management of allegations against foster carers and better safety planning in some areas. Safety planning, however, was still not embedded in practice in all areas.

Improvements were required in regard to care planning and review. Several areas had backlogs in relation to child-in-care reviews and in particular, service areas that held high numbers of unallocated children in care, also had a high number of care plans that were not up to date. The quality of care plans also varied and placement plans were not routinely completed in some areas.

The aftercare service was good in many of the 11 service areas, with six areas inspected being fully compliant and one substantially compliant with the related standard at the time of the inspection. There was excellent practice found in three of the 11 areas, in that they met all the requirements of the legislation and had well-developed aftercare services. Young people leaving care can be particularly vulnerable, and it is imperative therefore, that planning and preparation for leaving care is adequate. It is also vital that the support services provided, once a young person leaves care, are coordinated and tailored to meet their needs, in order to support them in their transition from care.

Excellent practice was found in the Sligo/Leitrim/West Cavan service area, the Kerry service area and the Cavan/Monaghan service area. All eligible children were allocated an aftercare worker regardless of their circumstances. In addition, some children who required support but did not meet the criteria for eligibility for an aftercare service, were allocated an after care worker and provided with an aftercare service. This demonstrated a commitment in these areas to ensuring young people transition from care in a planned way and with adequate supports to help them in their transition to adulthood.

While individual foster care inspection reports are published on www.hiqa.ie, a national overview report will also be published in the future on completion of phase 2 of this monitoring programme. This overview report will set out key national findings and trends across service areas and regions. This will be in the interest of

improving the overall governance of the foster care service, where required, to support and inform consistency of practice at both local, regional and national level.

7.4 Foster care – private

Children's foster care services are also provided by private non-statutory foster care agencies under agreements with Tusla. However, Tusla retains its statutory responsibilities to children placed with these services. Tusla also approves the foster carers through its foster care committees and the private foster care agencies are required to adhere to relevant standards and regulations, when providing a service on behalf of Tusla.

In the first three months of 2019, the Children's Team carried out an inspection of one new private foster care agency. The focus of the inspection was on recruitment, assessment, approval, supervision and review of foster carers. Overall, despite the service being relatively new at the time of the inspection, the agency was well run and delivered a high-quality service. However, there were some areas of practice that required improvement to enhance the good practice seen.

8. Regulation of special care units

There are three special care units in Ireland. These units are secure (locked) residential centres for children aged 11 to 17 years. The 2018 Overview report [22] referenced four special care units. Once these units became designated centres, only three applied to be registered as a special care unit and the fourth changed its purpose and function to that of a children's residential centre. Children are placed in special care by a court when it has been determined that they require care and protection, as their behaviour places them at risk. Children placed in special care receive therapeutic and educational supports in each unit.

All three special care units were registered by HIQA in November 2018 and their registration is due for renewal in 2021. Within the three-year registration cycle, special care units are monitored by HIQA to ensure ongoing compliance with the regulations and standards.

HIQA carried out monitoring inspections of all three special care units and one risk-based inspection in one of the units in 2019. The focus of the monitoring inspections was primarily on the regulations on leadership, governance and management, as these areas had previously been identified as requiring improvement. These inspections found that management structures had improved and this had ensured good levels of accountability for practice. There was also a level of stability at managerial level. However, national policies and procedures had yet to be finalised, and the arrangements to monitor and report on the quality of special care were not in compliance with the regulations at the time of the inspections.

All of the special care units were adequately staffed to care for the number of children placed in the centres at the time of inspection, but two were not resourced to provide the number of beds they were registered for. While the number of staff on duty at the time of inspection was adequate, agency cover was required on an ongoing basis to ensure these staff numbers were sustained. It was evident that special care was beginning to attract new staff and recruitment of new staff was ongoing.

There were improved systems in place to manage risk and managers were becoming more confident in their use. However, at the time of the inspections, the registered provider (Tusla) did not ensure all three centres had been reviewed in line with the regulations, to assure itself of their safety and effectiveness and to improve these services in a systematic way.

Overall, there were positive findings in relation to the quality of care provided to children placed in these units. Children's right to a voice and right to express their

views was promoted and they had influence, where possible, over decisions made about their lives. Each of the units had committees and groups in place which included children and through these mechanisms, children were able to contribute to changes; for example, to the décor of the units and the facilities provided. A new outcome-based model of care was introduced in all three special care units since their last inspections in 2018. This model emphasised the individuality of each child and the requirement of interventions that best suited their particular needs.

There was a concerted effort made across the three special care units to reduce the need for restrictive practices. This was particularly noticeable in Ballydowd Special Care Unit, where a considerable cultural shift had taken place which had resulted in a significant reduction in institutional practices. The inspection of Ballydowd found that these changes improved the quality of care experienced by the children placed there at that time.

In relation to absconding behaviour, there were similar findings across all three special care units. Absconding behaviour is where children have left, or have not returned to the unit, without permission from unit staff and are outside of the sight and supervision of a unit staff member. Despite risk management strategies and measures taken to bring about a reduction in such behaviour, there had been no sustained pattern of reduction. Some children were at potential risk when they had absconded and measures were being taken to address these risks. However, more needed to be done to improve the effectiveness of responses to children who repeatedly absconded and who were at potentially high risk as a result.

There are times when children make allegations against staff in special care units and the Chief Inspector must be notified by the units when this happens. A review of these allegations in 2019, showed that the majority of them related to the use of physical restraint during an incident. All allegations were reported by the units to the Child and Family Agency in line national child protection and welfare policy, to ensure that allegations were investigated. Inspectors found that no child remained at risk during these inspections and there were good safeguarding measures in place in the units. However, there was a lack of up-to-date national policy for special care units for managing allegations of this nature. This meant that there was a variation in how these allegations were responded to.

9. Oberstown Children Detention Campus

Oberstown Children Detention Campus is a national service that provides a safe and secure environment for young people remanded in custody or sentenced by the Courts for a period of detention. These young people have been committed to custody after conviction for criminal offences or remanded to custody while awaiting trial or sentence. The principal objective of the campus is to provide appropriate care, education, training and other programmes to young people between 12 and 18 years with a view to reintegrating them successfully back into their communities and society.

Oberstown is funded by the Irish Youth Justice Service (IYJS), an office within the Department of Children and Youth Affairs. Oberstown operates under a single Board of Management which is appointed by the Minister for Children and Youth Affairs.

HIQA inspects Oberstown Children Detention Campus annually, to ensure compliance with the *Standards and Criteria for Children Detention Schools* (2008) and its implementation of *Children First: National Guidance for the Protection and Welfare of Children* (2017).

In 2019, HIQA carried out an announced inspection of the campus. This inspection focused specifically on leadership, governance and management arrangements in place for the use of restrictive procedures and the delivery of programmes to address offending behaviour. It assessed the young peoples' experience of the use of restrictive procedures and the supports in place for them to break cycles of offending behaviour. Eight out of 10 standards were assessed as part of this process. At the time of the inspection, the service was compliant or substantially compliant with six standards and there was moderate non-compliance with the remaining two standards.

Overall, inspectors found that young people placed in Oberstown Children Detention Campus at the time of the inspection were provided with a good standard of care and it was evident that there were improvements to the quality of their lives through the opportunities made available to them. Their individual needs were taken into account in their day-to-day care and staff were supported to provide this care within an approved model and planning process. However, poor quality records did not always show how the young peoples' rights and best interests were consistently promoted as required whenever restrictive practices were used.

Restrictive procedures which involve high risk interventions such as physical restraint or the use of single separation, are not uncommon in places of detention for young people and their seriousness cannot be underestimated. Although restrictive

practices had reduced in 2019 compared to the year before, the use of restrictive practices remained significant. However, the commitment to promote the least restrictive living environment for young people was evident in the everyday opportunities provided to them. There was also a raised consciousness in staff to ensure the rights of young people who experienced restrictive procedures were promoted, such as the right to food and fresh air. Young people who met with inspectors were satisfied that this right was promoted during the time the young person was on single separation.

Young people were provided with opportunities to learn and develop skills which they would benefit from on their release and they were encouraged, through appropriate incentives, to engage with these programmes. Planning each young person's placement was a priority and each young person placed in the campus had a placement plan.

These plans ensured that their time spent in the campus was as beneficial and effective as possible. There was a multidisciplinary approach to placement planning which included therapeutic, medical, social work, educational and care input. Young peoples' attendance at planning meetings ensured they were actively involved in their own care and could take responsibility for meeting their own needs where possible.

There was a concerted effort to continually improve the quality and delivery of available programmes to address the young peoples' offending behaviour. There were five specific programmes being delivered aimed at addressing offending behaviour and ensuring young people's time spent in the campus was effective at achieving best outcomes for them.

There was a significant improvement in the range and frequency of evidence-based offending behaviour programmes for young people since the last inspection and it was encouraging to see that their engagement in these programmes was expected and promoted. However, there remained a need to ensure that programmes to address offending behaviour, were based on assessed needs and taking into account young peoples' tendencies towards specific types of offending behaviour.

The 2019 inspection found that the director, senior managers and the Board of Management were committed to reducing restrictive practices. There was evidence of a cultural shift which had begun to challenge previous practice and which promoted a less restrictive living environment for young people, while maintaining the level of security required to detain them.

There was an increased focus by the Board of Management on ensuring better governance arrangements were in place for the appropriate use of single separation.

This focus was being widened to ensure all restrictive procedures were being reported to the same level and subjected to the same level of scrutiny.

Throughout this inspection, it was evident that leadership was shown in relation to promoting the appropriate use and a reduction in restrictive procedures. Changes to the organisational structure had brought about necessary improvements in relation to decision-making, overall day-to-day management of the service and enhanced accountability arrangements. Managers who met with inspectors demonstrated responsibility for improving practice where opportunities to do so arose. As a result, there were good examples of improvements to practice and a noticeable enthusiasm for more. At an operational level, there were improved reporting arrangements in place on the use of restrictive procedures. These arrangements were supported by the introduction of an electronic case management system from which data and information could be stored and drawn. While this system remained under development, it had increased accessibility of information and data for relevant staff across the campus.

However, similar to previous inspection findings, this inspection highlighted a need to improve the quality of records and the effectiveness of information systems, in providing accessible, good quality and dependable data and information. Incident records were insufficient on their own to support effective monitoring of adherence to procedure and policy. Furthermore, these incident reports did not always accurately or fully record each event and so there was a potential risk that all restrictive practices were not being identified and reported as such. This lack of detail within some reports did not ensure managers reviewing reports had been notified of all incidents of physical intervention and did not fully support gathering of accurate data for monitoring, oversight, analysis and trending.

Although there were noticeable improvements towards reducing the need for restrictive procedures in Oberstown Children Detention Campus, more was required to ensure that all incidents of restrictive practice were recognised as such; that they were all subjected to the same level of scrutiny, and contributed to the overall picture of the use of restrictive procedures in the campus.

The mechanisms in place for responding to risk related to behaviour that challenged were good. There had been an investment in training for managers since the previous inspection of the campus, which strengthened service delivery. Improvements in the identification, reporting and management of child protection concerns were evident as there was an increased transparency in the management of such concerns. The young peoples' right to education was recognised at all times and their health needs were met.

Overall, the 2019 inspection found that the young people were cared for in a manner that safeguarded their rights. Improved governance arrangements were in place within Oberstown Children Detention Campus ensuring that young peoples' rights were upheld and promoted in all aspects of their care.

10. Stakeholder engagement

Engaging with people with experience of using social care services, the general public and the staff who work in or manage services is very important to HIQA. We do this through focus groups, forming advisory groups and as part of our inspection process, meeting or consulting with children, parents, foster carers and people with experience of social care and child protection services. Their views and feedback is essential in helping to inform our work and provide for more sustainable and informed decision-making.

Throughout 2019, the Children's Team continued to engage with various stakeholders and interested parties. Examples of these engagements are described in this chapter.

10.1 Children and their families

Over the course of 2019, inspectors met or spoke with 256 children and young people in a variety of settings, including mainstream residential care (35), child protection and welfare (22), special care (11), foster care (176) and detention (12). These children were keen to express their views in several key areas, including their experience of their care placement, their inclusion in planning for their care and aftercare, and their relationships and experiences of social workers.

10.2 Department of Children and Youth Affairs

The Children's Team continued to work with the Department of Children and Youth Affairs during 2019 to inform our regulatory and monitoring remit.

The Chief Inspector and Director of Regulation and HIQA's Head of Programme for Children's Services met with the Assistant Secretary of the Department and Chief Social Worker, Child Policy and Tusla Governance Division of the Department, every three months during 2019. These meetings were held to share relevant updates and exchange information on both improvements and actual and potential risk across those children's services that we monitor and regulate.

Members of the Children's Team liaised with Hub na nÓg within the Department of Children and Youth Affairs. Hub na nÓg supports Government departments, State

agencies and non-government organisations to give children and young people a voice in decision-making on issues that affect their lives.[±]

In October 2019, the Children's Team were represented at a one-day stakeholder event arranged by the Department of Children and Youth Affairs to explore what is working and what needs to change in relation to the current legislation, policy and operation of foster care services in Ireland. Subsequent events will be arranged by the DCYA to continue this consultative process which will inform any changes to the Child Care Act 1991.

10.3 The Child and Family Agency (Tusla)

During 2019, we met with senior members of the management team within Tusla to share information about annual business objectives; to discuss practice issues requiring improvement; to provide general feedback on inspection findings; to present on proposed changes to regulatory methodologies as relevant and to learn of new and ongoing developments in Tusla in relation to providing and quality assuring Tusla's child welfare and protection service. In August 2019, prior to commencement of fieldwork, the Children's Team presented to senior managers in Tusla on the focus of the Child Protection and Welfare Programme and the methodology to be used, including the assessment and judgement framework.

10.4 Oberstown Children Detention Campus

HIQA attended Oberstown's annual stakeholder event at which the Campus Director and Chairperson of the Board updated key stakeholders on progress made by the Campus over the course of its current strategy.

In October 2019, HIQA met with the Director of Oberstown Children Detention Campus to learn of ongoing developments in regard to its programme of care and to formalise meeting arrangements for 2020.

10.5 Department of Education and Skills

HIQA established a Memorandum of Understanding with the Department of Education and Science in early 2019. In line with the Memorandum of Understanding, contact is ongoing with the Department in regard to inspection findings of special care units and Oberstown Children Detention Campus as they relate to the education provided in these units.

10.6 Other stakeholders

The insights and experiences of other stakeholders are also very much valued by HIQA. The Children's Team met with the Empowering People in Care (EPIC)

[±] For further information, see https://www.hubnanog.ie/.

organisation in October 2019 and the Irish Foster Care Association in 2019. We attended a number of relevant events throughout the year, including events hosted by the Irish Penal Reform Trust, Tusla, Ombudsman for Children, and the Department of Children and Youth Affairs.

11. Concluding statement

The yearly work programme for the Children's Team is influenced by several factors. These include meeting legislative requirements, building on the previous years work programme and responding to risk. At the same time, HIQA wants to ensure our inspection and monitoring activities act as an agent of positive change and a means to promote quality improvement for the benefit of children. During 2019, this regulatory approach in the main highlighted:

- that children's lived experience of services influences their engagement with these services and provides a rich source of learning for the services involved
- that the embedded good practice seen can be even further enhanced by developing the skills and experience of staff, both in the interest of job satisfaction and staff retention and in the interest of the children who will benefit from that ongoing improvement and development
- that services have the capacity to use and build on the learnings identified both by their own self-assessments and or learnings arising from HIQA and Chief Inspector inspection findings and have, in the main, embraced these learnings
- that aspects of risk occur for different reasons, but that they primarily arise from poor governance which impact on outcomes for children, such as:
  - poorly developed systems for monitoring and oversight of day-to-day practice and the overall safety and quality of the service, which can lead to unidentified or unmanaged risk to children
  - failure to respond in a timely manner to the findings of quality assurance mechanisms, and
  - failure to regularly review and consistently implement the organisations' procedures and processes developed to guide and direct work with children and families.

How did the above manifest itself in our monitoring, inspection and regulatory activity during 2019?

- We observed services that had incrementally improved the quality of service provided to children and young people.
- We heard from a significant number of children and young people that they had received a child-centred service that reflected their individual needs. They had experienced being valued, minded and helped to cope with the struggles

that some of them faced, be they in alternative care settings, special care, detention or while on the child protection and welfare pathway.

- We have also heard from children of the difficulty they experienced being allocated a number of different social workers and hence not having the same sense of trust and value.
- We have seen that children who were deemed at immediate risk, for the most part, received a timely service that put safeguarding measures in place and monitored those arrangements.
- We also learned of children who were prioritised as high risk, who were awaiting allocation of a social worker.

Improvements

Reports published by HIQA in relation to the broad range of services regulated and monitored by the Children's Team have highlighted many improvements in children's services, and provide ample evidence of the ongoing commitment of staff and managers to provide safe and effective care. This is to be welcomed, as ultimately, children and in many instances their families or carers, will gain.

In addition, Tusla was implementing a specific approach to practice on a national scale, while at the same time embedding its electronic National Child Care Information System (NCCIS), to improve the reliability of information on which to report on, monitor and guide service provision on a local, regional and national basis.

Similarly, Oberstown Children Detention Campus had further developed its approach to delivering its programme of care to the children placed there and was continuing to enhance its governance arrangements and electronic information systems.

Challenges

Risks in some children's services remain and without doubt, Tusla continues to face a number of key challenges. These challenges primarily relate to the pace of implementing a workforce strategy that both involves attracting more social workers into the service and retaining current social work staff.

This impacted to a greater extent in some Tusla service areas, including the service areas subject to risk-based inspections, which was seen in their limited capacity to meet the demands placed on them, as well as managing existing children's cases on waiting lists.

The resulting cumulative effect of these challenges on children, their families and the children's foster carers, particularly the limited staffing resources in some service areas, has led to variations in the quality and timeliness of the services that children, their families and foster carers have received.

Finally, for the most part, we received an appropriate response to poor inspection findings. This demonstrates the provider's capacity to address deficiencies identified in inspection findings and to move forward in a more informed way. However, while improvement is clearly necessary and welcome, HIQA is not, and should not be, the first line of defence in ensuring a safe quality service for children, their families and their carers.

HIQA's monitoring and inspection function does not infringe upon the responsibility of the service provider to ensure strong oversight of its service and to put in place measures to respond to the ongoing challenges involved in providing a quality service. While this responsibility rests firmly with the provider, inspection findings and engagement with HIQA can support the development of a defined pathway to improvement.

Moving forward

The regulations and standards on leadership, governance and management of children's services have been and will continue to influence, the focus of the Children's Team in its work to support ongoing improvements across services. To that end, in 2020 we will implement a thematic programme of inspection of the governance, leadership and management of foster care services against the national standards. At the time of writing, a review of relevant literature relating to best practice in the governance of foster care services has commenced.

In line with how we plan and develop thematic inspections, we will produce guidance for Tusla on the inspection process and the assessment and judgment framework that will underpin our lines of enquiry. As part of the programme, service areas will also be requested to complete a self-assessment prior to on-site inspections to enable them to start to identify and focus on their strengths and weaknesses in advance of the inspections.

The proposed expansion of the remit of the Chief Inspector of Social Services to the regulation of all children's residential centres, statutory and non-statutory, will further enhance the protections available to children.

HIQA and the Chief Inspector of Social Services will work with the Department of Children and Youth Affairs to plan for the transfer of the registration and inspection functions for non-statutory children's residential centres from Tusla to the Chief Inspector within HIQA, when this process begins.

Finally, children and young people provide us with valuable insight into their direct experience of the services being inspected. The Children's Team is committed to further embedding how we promote and reflect the voice of children and young people in the work that we do. This includes expanding the ways in which we encourage and facilitate children and young people that we meet with while out on inspections to participate in those inspections.

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